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ABSTRACT

Burnout is a phenomenon in which the cumulative effects of a stressful work environment gradually overwhelm the defenses of staff members, causing them to psychologically withdraw. To understand the experience of professional and paraprofessional nurses suffering from burnout requires a close examination of the environments in which they function. A study was conducted to examine interpersonal (professional exposure to patients with poor prognoses for survival, work relationships, informal support), intrapersonal (coping strategies, fear of death, comfort working with patients with poor prognoses for survival), and situational (personal and work demographics) factors expected to contribute to the six dimensions of burnout among nursing staff who worked in acute care and long-term health care facilities. Professional and paraprofessional nurses (N=312) completed the Work Relationships Index of the Work Environment Scale and other measures assessing informal support; coping strategies; fear of death; and comfort working with, and professional exposure to, patients with poor prognoses. Burnout was measured by the Maslach Burnout Inventory. Findings revealed that Work Relationships, Tension-Releasing, and Instrumental Problem-Focused Coping were the most powerful predictors of burnout. Nursing burnout appeared to be both an organizational and a personal problem. Recommendations for practice are considered. (Appended are an extensive reference list and two tables dealing with the six dimensions of burnout and the other variables assessed.)

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Predictors of Burnout in Professional and Paraprofessional Nurses Working in Hospitals and Nursing Homes

(Predictors of Burnout in Nurses)

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ABSTRACT

Burnout is a phenomenon in which the cumulative effects of a stressful work environment gradually overwhelm the defenses of staff members, forcing them to psychologically withdraw. To understand the experience of professional and paraprofessional nurses suffering from burnout requires a close examination of the environments in which they function. This study examined interpersonal, intrapersonal and situational factors expected to contribute to the six dimensions of burnout among nursing staff who worked in acute care and long-term care health facilities. The sample included 312 professional and paraprofessional nurses. The following research question was explored using a series of stepwise multiple regression analyses: Of the following variables INTERPERSONAL [professional exposure to patients with poor prognosis for survival, work relationships, informal support.], INTRAPERSONAL [coping strategies, fear of death, comfort working with patients with poor prognosis for survival], AND SITUATIONAL [personal and work demographics], which are the significant predictors of the six dimensions of burnout in professional and paraprofessional nurses? Findings revealed that Work Relationships and Tension-Releasing and Instrumental Problem-focused Coping were the most powerful predictors of burnout. Based upon this, it was concluded that nursing burnout is both an organizational and a personal problem. Recommendations for practice are presented.

Predictors of Burnout in Nurses

Burnout is an adaptation to the progressive loss of idealism, energy, and purpose experienced by people working in the human services (Price and Murphy, 1984). According to Price and Murphy (1984), the typical burnout victim begins work full of idealism and a sense of mission; however, the difficult realities of the work situation lead to gradual disillusionment, resignation, and loss of spirit. Maslach (1982) describes burnout as a syndrome of emotional exhaustion, depersonalization and reduced sense of personal accomplishment that frequently occurs among individuals who work in the human services and in educational institutions. Storlie (1979) paints a vivid picture of burnout as it occurs in the nurse:

> "burnout [is] a highly personal happening inside the nurse--the literal collapse of the human spirit. It would be more useful and certainly more compassionate to ask what goes on in a professional nurse that transforms caring into apathy, involvement into distance, openness into self-protection, and trust into suspicion."
>
> (Storlie, 1979, p. 2108)

In addition to descriptive papers on nursing burnout (Storlie, 1979; Maslasch, 1979), recent empirical investigations have begun to describe this syndrome and to examine possible factors contributing to burnout among nurses (Jones, 1981; Jackson and Maslash, 1982; Yasko, 1983; West, Horan and Games, 1984; Keane, 1985). Drawing upon these works and the larger literature on work stress and burnout, several potential predictors of nursing burnout can be identified, including situational, interpersonal and intrapersonal factors. Among the situational factors are demographic variables such as age, marital status, and education (Cherniss, 1980) and work shift (Parasuraman, Drake and Zammuto, 1982). Given the differences in patient care responsibilities and resources experienced by professional versus paraprofessional nurses (e.g.,

certified nursing assistants) and in acute care versus long-term care facilities, the occupational role and work setting may also be identified as situational factors which potentially influence burnout.

In addition to situational variables, several interpersonal and intrapersonal variables have been identified in descriptive models of job stress as potential contributors to burnout (Cherniss, 1980; Maslasch, 1982). Some research has confirmed that social support received from the work peers (Duxbury, et al, 1984) and family and friends (Constable, 1983; Cronin-Stubbs and Rooks, 1985) reduce staff vulnerability to burnout. Intrapersonal characteristics related to burnout include personal coping strategies. Specifically, higher levels of burnout have been reported among professionals who utilized withdrawal coping strategies and lower levels among those who used social coping strategies, such as talking about work stress and getting advice (Maslasch and Jackson, 1982). Fear of death, discomfort with dying patients, and exposure to dying patients have also been discussed as potential contributors to burnout (Pruyser, 1984). Two empirical studies have investigated the last one of these possible relationships. One study confirmed that amount of exposure to dying patients was associated with higher levels of burnout (Dames, 1983) while the other found no relationship (Yasko, 1983) between exposure and burnout.

Building upon and expanding these earlier descriptive and empirical works, this current study examined the relationship of interpersonal, intrapersonal and situational (demographic) factors to burnout among professional and paraprofessional nurses who worked in acute care and long-term care facilities.

Procedure.

Directors of Nursing Services in ten facilities (three acute care hospitals and seven nursing homes) were contacted and given a thorough description of the study. Consent for participation in the research study was given by all of the facilities; however, each administrator was unwilling to release names and addresses of the nursing staff. Therefore, random sampling was not possible. Surveys were distributed to nursing employees by the Directors of Nursing Services. With the exception of one facility which attached surveys to all nurses' timecards, all others placed a stack of surveys in the nurses' report rooms with a flyer announcing the study and requesting the participation of registered nurses, licensed practical nurses, and certified nursing assistants. Data were collected for a period of six weeks. Flyers reminding staff to complete the questionnaire were posted on all nursing units in each facility one week, two weeks and three weeks after the first distribution of surveys. Respondents returned surveys directly to the researcher in a self-addressed, stamped envelope.

Measures.

Research on the role of social support in nursing burnout suggests that lack of support at work or from family and friends enhances staff's vulnerability to burnout (Constable, 1983; Duxbury, et al, 1984; Cronin-Stubbs and Rooks 1985). Therefore, both work support and informal support were selected as important variables to be examined. Work Support was assessed with The Work Relationships Index (WRI) of the Work Environment Scale (Moos, 1981). The WRI assesses 1) peer cohesion, 2) supervisor support, and 3) work involvement. The WRI has 27 true/false items and high internal consistency (Cronbach's alpha equaling .88, Moos, 1981). Empirical evidence from numerous sources supports the construct validity of the WRI as a measure of social support (Billings and Moos, 1981).

Informal Support was measured by one item, ("How satisfied are you with the support that you receive from friends and relatives?"). Responses ranged from 1="not at all satisfied" to 5="very satisfied." According to Gottlieb (1983), satisfaction is the most important variable in assessing the strength of an informal support system.

Coping Strategies were conceptualized as the cognitive and behavioral efforts to manage specific job-related demands which are perceived as stressful. Maslach and Jackson (1982) noted that high degrees of burnout in a variety of professions have been associated with withdrawal coping strategies, such as getting away from people, while low degrees of burnout have been associated with social coping strategies, such as talking with others about the job or getting advice. This variable was measured by the Jaloweic Coping Scale (Jaloweic, Murphy, and Powers, 1984), a 40 item, Likert-type scale that has been factor analyzed into four distinct coping strategies: 1) instrumental or problem-focused, 2) tension releasing, 3) morale maintaining, 4) other--directed. A coefficient alpha of .86 was reported (Jaloweic, et al, 1984) for the scale.

Fear of Death was operationally defined as an "emotional reaction involving subjective feelings of unpleasantness and concern based on contemplation and/or anticipation of any of the several facets related to death" (Hoelter and Hoelter, 1980). Fear of death was assessed with four subscales of the Multidimensional Fear of Death Scale (Hoelter, 1979), including fear of the dying process, fear of premature death, fear for significant others, and fear of the unknown. The mean reliability coefficient for the scale was reported as .75 alpha (Hoelter and Hoelter, 1980).

Comfort with Patients with a Poor Prognosis for Survival was assessed with a scale designed for this study. This scale was piloted with 25 nurses

who did not participate in the research project. The six-question Likert-type response scale measured comfort in caring for patients who have a poor prognosis for survival. Scores ranged from 6-30. The Cronbach alpha coefficient was .95 on the pilot sample and .87 on the study sample.

Professional exposure to patients with a poor prognosis for survival was measured by one question concerning amount of time on a typical shift spent caring for patients with a poor prognosis for survival. Type of facility was categorized as 1) acute care hospitals or 2) long-term care facilities. Occupational role was categorized into two groups: 1) professional nurses (e.g., registered nurses and licensed practical nurses) and 2) paraprofessional nurses (e.g., certified nursing assistants). Registered nurses and licensed practical nurses were pooled together for two reasons: 1) there were a limited number of LPN's in the sample (n=25) and 2) their job responsibilities and patient contact within the facilities were similar, except for the RN's ability to administer intravenous therapies. Personal demographics included age, marital status, family status (e.g., number of children at home) and educational level. Work demographics included shift, hours worked per week, type of facility, occupational role, and exposure to patients with poor prognosis for survival.

Burnout.

Burnout was measured by the Maslach Burnout Inventory (Maslach and Jackson, 1981) which separately assessed both the frequency and intensity of the three aspects of burnout: emotional exhaustion, depersonalization and personal accomplishment. Thus, this study utilized six dependent variables. A high degree of burnout was reflected in high scores on the Emotional Exhaustion and Depersonalization subscales and in low scores on the Personal Accomplishment subscale. Subscale reliability coefficients estimated by

Cronbach's coefficient alpha have been reported by Maslach and Jackson (1981) as the following: .90 for Emotional Exhaustion, .79 for Depersonalization, and .71 for Personal Accomplishment. Good external and internal validity are also report by Maslach and Jackson (1981).

Subjects.

Subjects were professional nurses (registered nurses and licensed practical nurses) and paraprofessional nurses (certified nursing assistants) who worked in acute care and long-term care health facilities in the Pacific Northwest. The sample was 94% female with a mean age of 37 (sd=11). Sixty-two percent of the subjects were married; 20% were single, 13% divorced, 2% separated, and 3% widowed. Sixty-six percent had at least one child.

Subjects had been working at their current facility an average of five years and had been in the field of nursing an average of 11 years. Of the total sample, 58% were registered nurses, 8% were licensed practical nurses and 34% were certified nursing assistants. Five levels of education were represented in this sample: 5% of the nurses had not completed high school; 28% were high school graduates; 36% held either an Associate of Arts Degree of a nursing diploma from a three-year program; 23% held a Bachelor's Degree, and 8% held a graduate degree.

Nurses reported spending varying amounts of time working with patients who had poor prognosis for survival. Forty-four percent of the nurses had low exposure (0 to 60 minutes per day); 42% had moderate exposure (one hour to five hours per day) and 14% had high exposure (five or more hours per day) to patients with poor prognosis for survival.

A total of 600 surveys were distributed. One hundred fifty-six surveys were received from acute care facilities and 156 from long-term care facilities. Three hundred twelve surveys were returned representing a 52%

response rate. It is possible that those nurses who were most burned out did not respond to the questionnaire. However, this possibility seems less likely given the range of burnout scores evident in the sample which was similar to that reported by other studies (Maslach, 1981). In addition, because of the low number of certified nursing assistant respondents who worked in acute care facilities (N=10), results from this study cannot be extended to paraprofessional nurses in such facilities.

Data Analysis.

The following research question was explored using a series of stepwise multiple regression analyses: Of the following variables INTERPERSONAL [professional exposure to patients with poor prognosis for survival, work relationships, informal support], INTRAPERSONAL [coping strategies, fear of death, comfort working with patients with poor prognosis for survival], and SITUATIONAL [personal and work demographics], which are the significant predictors of the six aspects of burnout in professional and paraprofessional caregivers? To reduce the number of independent variables, work demographics (shift, hours worked per week, exposure to patients with poor prognosis, type of facility and occupational role) were entered into the equation as a block. Age, educational level, family status, marital status were entered into the equation as a personal demographics block.

Findings.

Means and standard deviations for each measure are presented in Table 1. Across the six dimensions of burnout, work relationships and tension-releasing and problem-solving coping strategies were the most powerful and frequent predictors (Table 2). Altogether Work Relationships Index (WRI) Tension-Releasing Coping and Informal Support accounted for 45.4% of the variance in Emotional Exhaustion-Frequency. WRI was a negative predictor of

Emotional Exhaustion-Frequency; thus as WRI scores increased, Emotional Exhaustion-Frequency decreased. Specifically, 30.5% of the variance in Emotional Exhaustion-Frequency was accounted for by WRI scores. Taken with WRI, Tension-Releasing Coping was a positive predictor accounting for an additional 13.0% of variance in Emotional Exhaustion-Frequency. The final significant predictor was Informal Support which was negative predictor accounting for an additional 1.9% of the variance of Emotional Exhaustion-Frequency.

Altogether Tension-Releasing Coping, the Word Relationships Index (WRI), Instrumental/Problem-Focused Coping, and Informal Support accounted for 42.5% of the variance in Emotional Exhaustion-Intensity. Tension-Releasing Coping (such as eating, smoking, getting nervous, worrying, cursing, crying) was the strongest positive predictor of Emotional Exhaustion-Intensity, accounting for 28.1% of the variance in Emotional Exhaustion-Intensity scores. The WRI was a negative predictor of Emotional Exhaustion-Intensity, contributing another 13.4% to the variance. Taken together with Tension-Releasing Coping and WRI, Instrumental/Problem-Focused Coping, a negative predictor of Emotional Exhaustion-Intensity, and Informal Support, a positive predictor, each accounted for another 1.0% in the variance of Emotional Exhaustion-Intensity scores.

Altogether Tension-Releasing Coping, the WRI, Instrumental/Problem-focused Coping and Fear of Death accounted for 31.6% of the variance in Depersonalization-Frequency. Again, Tension-Releasing Coping significantly positively predicted Depersonalization-Frequency scores, accounting for 16.6% of the variance in Depersonalization-Frequency scores. WRI was a negative predictor, accounting for an additional 9.5% of the variance in Depersonalization-Frequency scores when taken together with Tension-Releasing

Coping. A third significant negative predictor of Depersonalization-Frequency was Instrumental/Problem-Focused Coping which accounted for another 3.5% to the variance. The final significant positive predictor was Fear of Death which added 2.1% to the variance of Depersonalization-Frequency.

Tension-Releasing Coping, th WRI, Instrumental Coping, and Personal Demographics accounted for 27.5% of the variance in Depersonalization-Intensity. Tension-Releasing Coping strategies significantly positively predicted Depersonalization-Intensity, accounting for 13.1% of the variance in Depersonalization-Intensity scores. WRI was a significant negative predictor, accounting for an additional 6.9% of the variance in Depersonalization-Intensity scores when taken together with Tension-Releasing Coping. Instrumental/Problem-Focused Coping was also a negative predictor, accounting for 1.6% of the variance in Depersonalization-Intensity. The final significant predictor was the block of Personal Demographics (age, educational level, marital and family status) which accounted for an additional 5.9% of the variance.

Taken together, Instrumental/Problem-Focused Coping, Comfort, Tension-Releasing Coping and WRI accounted for 30.6% of the variance in Personal Accomplishment-Frequency. In interpreting this regression for Personal Accomplishment, it is important to recall that high burnout was reflected in low scores in Personal Accomplishment-Frequency. Conversely, low burnout was reflected in high scores in Personal Accomplishment-Frequency. High scores in Personal Accomplishment-Frequency were positively associated with Instrumental/Problem-Focused Coping, accounting for 20.3% of the variance in Personal Accomplishment-Frequency. That is, the more respondents reported relying on instrumental/problem-focused coping strategies, the more frequently they felt a greater sense of personal accomplishment and lower sense of burnout. Comfort with patients with poor prognosis for survival contributed an

additional 5.1% of the variance in Personal Accomplishment-Frequency and Work Environment Support added another 1.6% of the variance. High scores on Personal Accomplishment-Frequency were negatively associated with Tension-Releasing Coping, accounting for an additional 3.6% of the variance.

High scores on Personal Accomplishment-Intensity were positively associated with only one significant predictor--that was coping which accounted for 13.0% of the variance for Personal Accomplishment-Intensity Coping. Again, the more nurses felt a sense of Personal Accomplishment, the more they relied on Instrumental/problem-focused coping strategies.

In summary, results of the multiple regression analyses revealed that the variables of primary importance in predicting burnout were the Work Relationship Index (WRI), Tension-Releasing Coping, and Instrumental/Problem-Focused Coping. Instrumental and Tension-Releasing Coping strategies were particularly powerful in predicting Depersonalization and Personal Accomplishment, while the WRI was particularly powerful in predicting Emotional Exhaustion (Table 2).

Those variables of secondary importance in predicting burnout in nursing staff were Comfort Working with Patients with Poor Prognosis for Survival, Informal Support, Fear of Death, and Personal Demographics. At least one of these four variables appeared as a significant predictor for five of the six dimensions of burnout (Table 2).

Discussion.

Interpersonal Sources of Burnout. Of the interpersonal variables, the Work Relationship Index (WRI) was the most powerful, negatively predicting all dimensions of burnout with the exception of Personal Accomplishment-Intensity. These results are consistent with other studies which suggested that lack of support at work enhances nursing staffs' vulnerability to burnout (Constable

1983; Duxbury, et al, 1984; Cronin-Stubbs and Rooks, 1985). Because of the cross-sectional design of the study, it is not possible to determine the exact direction of the relationship between burnout and work relationships. It is possible that while poorer work relationships may contribute to burnout, burnout may also further reduce the quality of the work relationships (Maslach, 1982). The majority of nurses in this current study fell into a moderate range of emotional exhaustion (Maslach, 1982) and this emotional exhaustion may have contributed to reduced supportive relationships at work. In short, burnout and work environment may reciprocally influence one another.

In this study satisfaction with informal support from family buffered nurses against the Emotional Exhaustion. While this contrasts with findings from one earlier study (Jackson and Maslach, 1982), other studies have found that people who receive help and assistance from informal support systems are less negatively affected by stress (Cassel, 1976; Cobb, 1976; Dean and Lin, 1977: Kaplan, Cassel and Gore, 1977). Therefore, it is not surprising that satisfaction with informal support was negatively related to both the frequency and intensity of emotional exhaustion experienced by nurses in this sample.

Intrapersonal Factors Associated with Burnout. Of the intrapersonal variables related to the six dimensions of burnout, Tension-Releasing Coping and Instrumental/Problem-focused Coping were the strongest and most frequent predictors of burnout. Tension-Releasing Coping was particularly powerful as a positive predictor of Emotional Exhaustion and Depersonalization while Instrumental coping was a strong negative predictor of Personal Accomplishment.

Both two coping strategies serve important but different psychological functions. Instrumental/problem focused coping functions to manage or alter the source of stress while tension-releasing coping is emotion-focused and regulates distressful emotions which occur in response to stress (Lazarus and

Folkman, 1984). While emotion-focused coping has been reported (Lazarus and Folkman, 1984) to be a potentially effective, short-term strategy for reducing stressful emotions, the tension-releasing items on the Jaloweic scale are essentially negative behaviors (e.g., smoking, cursing, withdrawing from the situation) and may not be effective behaviors in regulating stressful emotions, particularly over the long term. Thus, it is not surprising that such tension-releasing coping strategies appeared to be ineffective in reducing burnout and, in fact, were related to greater burnout.

This finding is consistent with those of Chiriboga, Jenkins and Bailey (1983) who found that the use of emotional avoidance as a coping strategy was associated with less favorable outcome for hospice nurses. These same researchers found that nurses who maintained a professional attitude seemed to fare best. The behaviors associated with instrumental coping strategies (e.g., trying to maintain some control over the situation and looking at the problem objectively) appeared to coincide with those described by Chiriboga, et al (1983) as "professional attitude" and also were negatively related to burnout.

Amount of exposure to patients with poor prognosis for survival was not associated with burnout, confirming the findings of Yasko (1983). However, comfort with such patients predicted one dimension of burnout, that is, frequency of Personal Accomplishment. As nurses felt less comfortable with patients with poor prognosis for survival, they more frequently felt a reduced sense of personal accomplishment. Maslach (1982) noted that when individuals recognize that they have become detached and callous, they often feel distress and/or guilt about their interactions with clients. They may feel a growing sense of inadequacy and may think of themselves as failures. This is reflected in the third aspect of burnout: reduced personal accomplishment.

Similarly, Fear of Death was a significant predictor of one dimension of burnout, the frequency of depersonalization. Nurses who were more fearful of death, more frequently reported experiencing unfeeling, impersonal responses towards patients in their care. Considerable descriptive literature discusses the dilemmas facing caregivers to the terminally ill and the resulting isolation suffered by these patients in hospitals and nursing homes (Kastenbaum, 1967; Strauss, 1968; Fulton, 1971; Rando, 1984; Pruyser, 1984). Pruyser (1984) contends that in response to the emotional difficulties faced by caregivers to dying patients, these caregivers resort to defensive coping, such as "surrounding [their] heart[s] with armour" (p. 358). The relationship found in this study between fear of death and frequency of depersonalization felt by nurses supports Pruyser's notion.

Situational Factors Associated with Burnout. Personal demographics was a significant predictor of Depersonalization-Intensity. However, several variables (age, level of education, marital status and family status) were entered into the regression equation as a block, it is not possible to interpret the independent contribution of each. It is important to note that a relatively small percentage (5.9%) of the variance was accounted for by this entire block of variables. Overall, it is clear that personal demographics have considerably less power as predictors of many dimensions of burnout than do interpersonal and intrapersonal factors. Similarly, work demographics such as occupational role, facility, and shift were not significant contributors to burnout. It appears that it is the interpersonal ability of the nurse to effectively use coping strategies and the social characteristics of the work environment that are the most important contributors to nursing burnout among professional and paraprofessional nurses in both acute and long-term care facilities.

Summary and Recommendations. While these several specific variables predicted individual dimensions of burnout, the most powerful predictors across the six dimensions of burnout were the Work Relationships Index (WRI), Tension-Releasing Coping and Instrumental/Problem-focused Coping. Based upon this, it is concluded that nursing burnout is both an organizational and a personal problem.

Reaching beyond the study, it is assumed that the problem of burnout very likely increases the financial costs of the care and ultimately decreases the quality of care received by patients. As such, interventions aimed at reducing burnout may focus both upon organizational issues, such as supervisory support and peer relationships and upon assisting staff to use instrumental coping strategies, perhaps through staff training and work-related counseling. However, given that facilities have the greatest control over organizational rather than personal issues (Cherniss, 1980), improving the quality of the work environment relationships would appear to be the most effective intervention aimed at reducing the risk for burnout among nursing staff in both acute care and long-term care facilities.

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Table 1

Means, Standard Deviations, and Possible Ranges of Six Dimensions of Burnout, Work Relationsips, Informal Support, Fear of Death, Comfort with Patients, Coping Strategies.
(n=312)

	Mean	(sd)	Range Possible
Burnout Dimensions			
Emotional Exhaustion/Frequency	23.7	(11.8)	0- 54
Emotional Exhaustion/Intensity	32.9	(12.4)	0- 63
Depersonalization/Frequency	7.7	(6.1)	0- 30
Depersonalization/Intensity	11.1	(8.0)	0- 35
Personal Accomplishment/Frequency	31.8	(6.9)	0- 48
Personal Accomplishment/Intensity	34.4	(7.5)	0- 56
Work Relationships	16.6	(6.0)	0- 27
Informal Support	4.2	(2.9)	1- 5
Fear of Death	58.6	(11.0)	28- 92
Comfort with Patients	25.1	(4.7)	6- 30
Coping Strategies			
Instrumental	42.0	(5.6)	12- 60
Tension-Releasing	37.3	(7.1)	16- 80
Morale Maintaining	25.6	(4.0)	9- 45
Other-Directed	9.3	(1.6)	3- 15

Table 2: Significant Predictors of Six Dimensions of Nursing Burnout

(N=312)

Predictors	Emotional Exhaustion Frequency ΔR^2	Emotional Exhaustion Intensity ΔR^2	Depersonalization Frequency ΔR^2	Depersonalization Intensity ΔR^2	Personal Accomplishment Frequency ΔR^2	Personal Accomplishment Intensity ΔR^2
Interpersonal						
Work Relationships	.305	.134	.095	.069	.016	---
Informal Support	.019	.010	---	---	---	---
Intrapersonal						
Instrumental Coping	---	---	.035	.016	.203	.130
Tension-Releasing Coping	.130	.281	.166	.131	.036	---
Fear of Death	---	---	.021	---	---	---
Comfort with Patients with Poor Prognosis	---	---	---	---	.051	---
Personal Demographics	---	---	---	.059	---	---
Total R^2	.454	.425	.316	.275	.306	.130
Total F	108.75	97.40	49.65	37.65	62.74	36.77

$p \leq .05$